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|  |  |   |         |                               |   |  |  |
|--|--|---|---------|-------------------------------|---|--|--|
| FIRST STEPS CBIS PROVIDER ENROLLMENT FORM  |  |   |         | PROVIDER ID # _____           |   | FS OFFICE USE ONLY<br>Program Consultant(s) _____<br>DATE: _____   |  |
| <input type="checkbox"/> New   |  | <input type="checkbox"/> Contract Renewal |         |                               |   |  |  |
| <input type="checkbox"/> Addendum  |  | *Indicate (A) Add, (D) Delete             |         |                               |   |  |  |
| SECTION 1: BILLING INFORMATION   |  |   |         |                               |   |  |  |
| 1. Business Name   |  |   |         | 2. Federal Tax ID/Soc. Sec. # |   |  |  |
| 3. Street Address Line 1   |  |   |         |                               |   |  |  |
| 4. Street Address Line 2   |  |   |         |                               |   |  |  |
| 5. City  |  | 6. State                                  |         | 7. Zip                        |   | 8. First Steps Contract Administrator:<br>Name: _____ Email: _____ |  |
| 9. Telephone   |  |   | 10. Fax |                               | 11. Billing Contact Person (if Different from Administrator):<br>Name: _____ Email: _____ |  |  |
| 12. Tax Status: (Circle One):<br>A. Individual      B. Sole Proprietorship      C. Partnership      D. Estate/Trust<br>E. Corporation      F. Public Service Corporation (PSC)      G. Government/Non-Profit |  |   |         |                               |   | 13. District(s) Served: _____                                      |  |

| SECTION 2: SOURCES OF ALTERNATE FUNDING |        |
|---|--------|
| SOURCE                                  | AMOUNT |
|   |        |
|   |        |

Please indicate any additional sources you currently have to provide services to KEIS eligible children. NOTE: This information will not be used in any way to deny payment of KEIS eligible services. This information is simply to provide KEIS with an understanding of how much funding is adequate to meet the early intervention needs of children in Kentucky.

[illegible]

**FIRST STEPS**  
KENTUCKY'S EARLY INTERVENTION SYSTEM

**Page 1 of \_\_\_\_:** (Upper right hand corner) If you only use Form 6 it will be Page 1 of 1. If a continuation page is required to list all the individuals who will be providing services for your provider entity, you will also use Form 6A (which can be downloaded/printed through this link). Then you would indicate Page 1 of 2, for instance.

**Application Type:**

**New:** Check if this is a new application.

**Contract Renewal:** Check if this is a contract renewal.

\*Addendum: Check if this is an addendum/change

For addition or deletion of Service Provider use the following letter codes in the first column of Section 3: **(A)** Add; **(D)** Delete.

# FORM 6: CBIS PROVIDER ENROLLMENT

## SECTION 1.

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FORM 6 Revised 7-04

|  |   |         |   |                               |  |   |  |
|--|---|---------|---|-------------------------------|--|---|--|
| FIRST STEPS CBIS PROVIDER ENROLLMENT FORM  |   |         |   | PROVIDER ID # _____           |  | <b>FS OFFICE USE ONLY</b><br>Program Consultant(s) _____<br>DATE: _____ |  |
| <input type="checkbox"/> New   | <input type="checkbox"/> Contract Renewal |         |   |                               |  |   |  |
| <input type="checkbox"/> Addendum *Indicate (A) Add, (D) Delete  |   |         |   |                               |  |   |  |
| SECTION 1: BILLING INFORMATION   |   |         |   |                               |  |   |  |
| 1. Business Name   |   |         |   | 2. Federal Tax ID/Soc. Sec. # |  |   |  |
| 3. Street Address Line 1   |   |         |   |                               |  |   |  |
| 4. Street Address Line 2   |   |         |   |                               |  |   |  |
| 5. City  | 6. State                                  | 7. Zip  | 8. First Steps Contract Administrator:<br>Name: _____ Email: _____                        |                               |  |   |  |
| 9. Telephone   |   | 10. Fax | 11. Billing Contact Person (If Different from Administrator):<br>Name: _____ Email: _____ |                               |  |   |  |
| 12. Tax Status: (Circle One):<br>A. Individual    B. Sole Proprietorship    C. Partnership    D. Estate/Trust<br>E. Corporation    F. Public Service Corporation (PSC)    G. Government/Non-Profit |   |         | 13. District(s) Served:   |                               |  |   |  |

## SECTION 1. BILLING INFORMATION

1. Business Name: This should be the name of the business/individual listed as the provider on page 1 of Form 5: Provider Agreement.
2. Federal Tax ID #/Social Security #: The Internal Revenue Service requires that we have a Tax Identification Number on file for any company or individual we pay. Your Tax Identification Number is a Federal Employer Identification Number or a U.S. Social Security Number.
- 3.-7. Address (Street Address, City, State, Zip): Enter your complete mailing address. This is the address to which all First Steps related correspondence, including checks, will be sent.
8. First Steps Contract Administrator: DO NOT LEAVE BLANK. This is the name and e-mail address of the person to contact for information concerning providers.
9. Telephone: Do not leave blank. List the phone number for the contact person in # 8.
10. Fax: List the fax number for the contact person in # 8.
11. Name and E-Mail Address of Billing Contact Person: Do not leave blank if different from person listed in #8. In the event CBIS has questions regarding billing, this is the person that will be contacted. It does not necessarily have to be the authorized provider or the contact person named on the Form 5 Provider Agreement or in #8 on this form. List an e-mail address that can be used to direct CBIS inquires or correspondence to the billing contact person.
12. Tax Status: Circle one to indicate your tax status.
13. District(s) Served: Do not leave blank. List district(s) in which counties served are located.

## SECTION 2.

| SECTION 2: SOURCES OF ALTERNATE FUNDING |        |
|---|--------|
| SOURCE                                  | AMOUNT |
|   |        |
|   |        |

Please indicate any additional sources you currently have to provide services to KEIS eligible children. NOTE: This information will not be used in any way to deny payment of KEIS eligible services. This information is simply to provide KEIS with an understanding of how much funding is adequate to meet the early intervention needs of children in Kentucky.

## SECTION 2: SOURCES OF ALTERNATE FUNDING

List sources of alternative funding. See definition to the right of the box. If you have no other source of funding for First Steps related services, write none in the box.

### SECTION 3.

[illegible]

### SECTION 3: SERVICE PROVIDER(S) AND DISCIPLINE(S)

## COLUMNS

**\*A/D**

New Providers: Leave Blank

**Contract Renewals:** Leave Blank

Addendum:

Enter “A” if adding an individual to your existing FS provider agreement.

Enter “D” if deleting an individual from your existing FS provider agreement.

**SERVICE PROVIDER(S)**

Enter the individual's name. If he/she is a licensed or registered provider, list the name as it appears on the license or registration.

New Provider/Contract Renewal: Enter the name of each individual that will provide First Steps services under the provider agreement, including yourself if you will be providing services under this agreement. *If the individual is an active or retired state employee, enter the code SE beside his/her name.*

Addendum: Enter the name of each individual for which you are submitting a change (add, name change, etc.). *If the individual is an active or retired state employee, enter the code SE beside his/her name.*

**SOCIAL SECURITY #**

Do not leave blank. Enter the social security number for each individual listed.

**DISCIPLINE CODE**

Refer to Form 9: Codes of Disciplines. Enter the appropriate two-digit discipline code for each professional discipline for which the individual listed will provide services and bill First Steps. In order to be a provider, each individual must meet the requirements for that discipline as specified in 911 KAR 2:150.

**LICENSE #**

In addition to recording the license number in the space provided, legible copies of professional license(s) and/or certificate(s) must be sent for each individual listed.

**COUNTY(IES) BEING SERVED**

List each county in which the individual will provide FS services.